TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JAVIER S. HERNANDEZ, DC

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-16-3372-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
JULY 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $400.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reviewed the bill and issued reimbursement in the amount of $400.00. After submitting a request for reconsideration, the Carrier used an additional reimbursement of $400.00, bringing total reimbursement for the billed services to $800.00…The Provider contends they are entitled to reimbursement. The Carrier has reviewed the documentation and determined the Provider is previously been issued appropriate reimbursement for the disputed services. No additional reimbursement is appropriate under the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation."

Response Submitted By: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2015	CPT Code 97750-FC(X16)	$400.96	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and 203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 600-Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- W3-Additional payment made on appeal/reconsideration.
- 947-Upheld no additional allowance has been recommended.

Issues

Is the requestor entitled to additional reimbursement for the functional capacity evaluation rendered on December 17, 2015?

Findings

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

CPT code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." CPT code 97750 requires direct one-on-one patient contact.

A review of the submitted Functional Capacity Evaluation report indicates "TOTAL TEST TIME: 4 Hours."

28 Texas Administrative Code §134.204 states that FCEs shall be reimbursed in accordance with §134.203(c)(1).

28 Texas Administrative Code §134.203(c)(1) states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83."

28 Texas Administrative Code §134.203(c)(2) states "The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

The Division conversion factor for 2015 is $56.2.

The Medicare conversion factor for 2015 is 35.9335.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 79925 which is located in El Paso, Texas; therefore, the Medicare locality is "Rest of Texas."

The Medicare participating amount for CPT code 97750 is $31.97.

Using the above formula, the MAR is $50.00 per unit. The requestor billed for 16 units; therefore, $50.00 X 16 $800.00. The respondent paid $800.00. The difference between MAR and amount paid is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/30/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

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Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.